DATE____________________

PATIENT'S NAME: MR MS___________________________________ AGE_____ DATE OF BIRTH ____/____/____ SS# ________________________________

ADDRESS__________________________________________________CITY_______________________STATE_______ZIP_______________

HOME PHONE: (          )______________________________ DAYTIME PHONE: (          )__________________________________

CELL PHONE: (          )______________________________ E-MAIL ADDRESS: ______________________________________________

OCCUPATION: ________________________________________ EMPLOYER: ___________________________________________________

WHOM MAY WE THANK FOR REFERRING YOU TO US? (PLEASE CHECK ONE)

_____ FAMILY / FRIEND: NAME:________________________________________________________

_____ DOCTOR: NAME:________________________________________________________
_____ OUR OFFICE WEBSITE
_____ OTHER INTERNET SITE: NAME:________________________________________________________
_____ INSURANCE COMPANY
_____ YELLOW PAGES BOOK
_____ ADVERTISMENT
_____ SAW BUILDING OR SIGN

PREFERRED LANGUAGE: _____ ENGLISH _____ SPANISH

RACE: _____ AMERICAN INDIAN OR ALASKA NATIVE _____ ASIAN _____ BLACK OR AFRICAN AMERICAN
_____ HISPANIC _____ NATIVE HAWAIIAN / PACIFIC ISLANDER _____ WHITE

ETHNICITY: _____ HISPANIC OR LATINO _____ NATIVE HAWAIIAN / PACIFIC ISLANDER _____ NOT HISPANIC OR LATINO

WHAT IS YOUR PREFERRED METHOD OF COMMUNICATION?
_____ E-MAIL _____ POSTAL _____ TELEPHONE

NAME OF SPOUSE, PARENT, OR GUARDIAN (if applicable)______________________________________ PHONE: (        )_________________

NAME OF CHILDREN (if applicable) ____________________________________________________________________________________

WHOM MAY WE CONTACT IN THE CASE OF AN EMERGENCY? ________________________________ PHONE: (        )_________________

APPROXIMATE DATE OF LAST EYE EXAMINATION: ___________________________ BY DOCTOR ______________________________________

DO YOU HAVE VISION INSURANCE? ____YES ____NO

VISION INSURANCE PLAN:
- ☐ EYEMED
- ☐ BLUE VIEW
- ☐ DAVIS
- ☐ TRICARE STD ☐ Active ☐ Retired
- ☐ TRICARE PRIME ☐ Active ☐ Retired
- ☐ BLUE VISION
- ☐ VSP
- ☐ OTHER___________

POLICY HOLDER ID #: ________________________________

POLICY HOLDER NAME: ________________________________

POLICY HOLDER EMPLOYER: ________________________________

POLICY HOLDER DATE OF BIRTH: ________________________________

DO YOU HAVE MEDICAL INSURANCE? ____YES ____NO

MAJOR MEDICAL INSURANCE PLAN:
- ☐ ANTHEM BCBS
- ☐ AETNA
- ☐ CIGNA
- ☐ MEDICARE
- ☐ UNITED HEALTH CARE
- ☐ SENTARA / OPTIMA : MEMBER ID#_______________
- ☐ TRICARE STD ☐ Active ☐ Retired
- ☐ TRICARE PRIME ☐ Active ☐ Retired
- ☐ OTHER _____________

POLICY HOLDER ID #:__________________________________

POLICY HOLDER DATE OF BIRTH: _______________

Rev:Sep 14, 2012